



840 Winter Street
Waltham, MA 02451
Tel: (781) 895-4901
Fax: (781) 895-4902

March 4, 2010

Please accept this written testimony on behalf of Boston Out-Patient Surgical Suites in response to the request dated February 12, 2010.

If you have any further questions or are in need of any additional information, please do not hesitate to contact me at the above number or at gregd@bostonoutpatient.com

Sincerely,

A handwritten signature in black ink, appearing to read "Gregory P. DeConciliis". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Gregory P. DeConciliis, PA-C, CASC
Administrator

Signed under the pains and penalties of perjury on this 4th day of March.

Gregory P. DeConciliis, PA-C, CASC
Boston Out-Patient Surgical Suites

Exhibit B Answers

1) Upon review of the executive summary, a number of similarities exist in terms of the findings and the trends we have experienced overall as a facility over this time frame. First and foremost, I applaud the Division of Health Care Finance & Quality (the Division) for allowing us to “come to the table” with this commentary, as I truly believe freestanding Ambulatory Surgery Centers (ASC’s) are truly an integral part of (as you say in the last line of your introduction) “slowing the growth in health care costs while maintaining quality of care.” I believe it is going to be the true analysis of the testimonies of the four ASC’s requested, that will empower the Division to provide recommendations to the legislature on behalf of ASC’s.

From the referenced report, and in regards to higher prices, there is a clear correlation between Hospital Outpatient Departments (HOPD’s) and ASC’s. In 2009, for example, it is estimated that ASC reimbursement will be only 59% of HOPD reimbursement on average. The key component of that, however, is this cost savings is on the *exact same* procedure. This concept has been exhibited by Medicare whereby in 2006 alone, ASC’s saved Medicare and its beneficiaries 1.7 billion dollars. The exact same service, provided in a different setting, at a cost savings. Facilitating access to utilization of ASC’s as an answer alone will save Massachusetts money.

This leads into the second portion of the trend which is greater utilization of services in HOPD’s. It is my understanding, garnered through knowledge of trends disclosed by colleagues through my work with the Massachusetts Association of Ambulatory Surgery Center (MAASC), that hospitals are entering into direct relationships with physicians, whether through direct employment or “affiliations” or “arrangements”, whereby referrals are being directed back to the hospitals. While I have not experienced this, per se, as directly impacting my Center in terms of the regular utilizers of my facility, I can empathize with the ASC’s in areas where these practices are occurring, and worry that the trend is heading in this direction. This is why I support House Bill No. 1855 which I have attached as an Appendix to this testimony.

The other aspect of this utilization issue that is important, is in reference to the legislative burden that has been placed on ASC’s in Massachusetts. Since 1995, the Department of Public Health (DPH) Determination of Need (DON) Programs has had a “no need, no file” policy for freestanding multispecialty ASC’s. This means, in essence, do not bother filing, you will not be allowed to build. Single specialty ASC’s have faced similar obstacles and efforts by the MAASC to repeal these restrictions have been fruitless. This, therefore, bears a clear correlation with Massachusetts having higher health care expenditures and utilization of HOPD’s when compared with the rest of the nation. The legislation has protected the hospitals by limiting competition. By repealing this antiquated legislation, Massachusetts healthcare will be able to take advantage of our cost savings.

2a). Upon analysis of our revenue trend from 2006 to 2008, findings emphasize a direct correlation with procedure volume. This period was a time of tremendous maturity for our facility, and with maturity came increased utilization from ancillary physicians who were looking for a more efficient, higher quality setting, complete with all of the latest equipment, to perform their procedures. Surveying any surgeon who utilizes an ASC, I can guarantee you they will share the tremendous quality we exude. We allow them to perform more procedures in less time (for example, if a surgeon in a hospital performs 5 cases from 7:30 to 5:30, in an ASC they can perform 8 cases, at least, from 7 to 3:30), which frees them up to deal with crucial tasks such as emergency room coverage and procedures, seeing patients, following up with patients, research and development, or just as important- time with their families! We do this because of our efficiency- efficiency in the personnel we have on staff who strive to ensure turnover time between cases is at a minimum, they have knowledge and retention of what is expected for each surgical case, and they utilize down time to their maximal ability. The efficiency also comes, however, in terms of medical supply usage. Our staff is trained to open only the items that are needed for the case, and wait for the others until there is a request. For someone not familiar with how operating rooms work this is a hard concept to truly understand, but having worked as an employee of a hospital for 4+ years, I have firsthand experience on the amount of wasted medical supplies on each and every procedure. This, again, adds to our efficiency and how we control costs and maximize revenues. Unfortunately, however, because of the disparity amongst payments between ASC's and HOPD's, this type of efficiency is not an option, it is a necessity. As we have to relish every procedure we can get, we also have to maximize the efficiency in which we provide that procedure.

2b) This facility does not provide outpatient imaging services, therefore I have no comment on this subject.

2c) As a Center, our facility fees have been dictated by a management company with a formula tied to Medicare reimbursement. Consistency has remained in the formula and pricing, with awareness of declining Medicare reimbursement. In 2003, Medicare paid ASC's an average of 86.5% of HOPD rates. Since that time, our disparity with HOPD rates has increased dramatically, with the average in 2010 dropping to 57.9%. As referenced above, in order to maintain growth at our Center, we've had to add volume through additional surgeons.

I believe as a state Association, we have done tremendous work in educating insurance companies, particularly the larger ones in Massachusetts, and working closely with the insurance companies to analyze our reimbursement. We have worked with them on attempting parity with the HOPD's, although these efforts have been fruitless, for the most part. They have made it clear that they want to reap the benefits of paying ASC's less for the same services, yet in the same breath they have been slow to accept the addition of procedure codes and proper adjustments to cover escalating supply costs. This is discouraging, especially as you now realize (from this testimony) that we champion competition, and we do not mind performing the same procedures for less money because we know we are more efficient. We do, however, not want our patients to be subject to higher deductibles or co-payments for utilizing ASC's, and having to

undergo frivolous pre-authorizations for procedures. These efforts drive patients out of our facilities, and are frankly unfair. Efforts by the Division to curtail these practices will continue to allow patients to be serviced in our setting, therefore decreasing overall health care costs.

3) As referenced above, Boston Out-Patient Surgical Suites (BOSS) as a facility has experienced an increase in volume during the referenced period, but only due to the recruitment of physicians. This, essentially, is a measure of my worth as an Administrator of the Center, and is what I have prided myself on doing. These efforts are ongoing, unfortunately, as time and time again physicians are lured back to the hospitals for a variety of reasons. As I mentioned above, I am unaware of any direct “arrangements” which have prevented surgeons from utilizing our facility, however I am aware of tactics that hospitals use to lure physicians back that have affected us. From offering the surgeons increased block time or the usage of two blocks on a surgical day, to the frank threatening of taking away a surgeon’s block time, I’ve heard of numerous techniques. Unfortunately, the latter technique is a serious consequence to a surgeon and often ultimately gets them back. Without dedicated OR block time at a hospital, the surgeon does not have the necessary flexibility to bring a patient who needs to utilize a hospital for a medical condition, is a potential inpatient case, or simply out of patient choice.

In regards to our historical trend, there exists a parallel between the findings of the Division report and the utilization at our facility. We issue a block of surgical time to a surgeon. Whether he or she fills that time is a function of volume. So, during this period of growth in overall volume for our Center, the actual utilization of those awarded blocks of surgical time was on par with the numbers in the report. They are as follows:

<u>Year</u>	<u>Overall Percentage Block Utilization</u>
2006	58.5%
2007	62.7%
2008	60.9%

Extrapolating these numbers, we experienced an increase of 4.2% from 2006 to 2007, however a further decrease from 2007 to 2008 of 1.8% (and an overall increase over the period of 2.1%). Again, this is a true mark of not only minimal growth out of proportion to the growth of HOPD’s, but also, as a number, reflects the tremendous underutilization of our facility. This number, in reality, dips down into the low 50’s percent when I include our Pain Management practice and the underutilization of the Procedure Room, in which these and other local procedures take place. These numbers, for the Division, represent an opportunity to facilitate increased utilization of lower-cost facilities for patients in Massachusetts, thus lowering health care expenditures.

One final note in regards to utilization. The reports findings of “outpatient procedures and cancer therapies provided in hospital outpatient facilities {contributing} heavily towards growth in expenditures” should not be discouraging. Technological advances continue to amaze me every day! We are fortunate, as a nation, that we often lead the way in these advances, and that many of them have allowed us to perform surgeries that have been traditionally performed on an inpatient basis now safely in an outpatient setting. This should, hypothetically, save us money, as outpatient facilities do

not have to carry the financial burdens of increased overhead that hospitals do. Again, it is just a matter of promoting parity amongst the outpatient facilities, ASC or HOPD, that will indeed save Massachusetts money in the long run.

4) Boston Out-Patient Surgical Suites was founded by 16 physician owners, in collaboration with our anesthesia group, Anesthesia Associates of Massachusetts (AAM), a management company Ambulatory Surgical Centers of America (ASCOA), and the New England Baptist Hospital(NEBH). Due to prior restrictions on non-physician ownership, the ownership of the corporate entities mentioned above resided in a management company for the BOSS entity. Following the legislative changes enacted in 2009, the two entities merged into one in 2010, giving these corporate entities primary ownership in BOSS.

Almost all of the physicians who utilize our facility are in private practice in Boston and the Metropolitan Boston area. Therefore, considering referrals do not come directly to the facility, they are directed through these private practices. The majority of our physicians also operate at the NEBH, while the remaining physicians also operate at Brigham & Women's Hospital (BWH) or other community hospitals throughout Boston. Speaking in terms of our NEBH physicians, some physicians do see patients through their Occupational Health Division, as well as derive referrals from specialists and Primary Care Physicians (PCP's) who are employed by NEBH.

I would consider the NEBH ownership in our facility, obviously, a formal arrangement, however, curiously enough; the NEBH has its own outpatient facility New England Baptist Surgicare. Coincidentally, as BOSS began operations, the NEBH was forced to recruit other physicians to fill its Operating Room (OR) time. To the best of my knowledge, they were mildly successful at doing this, and, they maintained a significant group of physicians who performed outpatient surgeries on staff to fill their OR time. We have experienced competition for volume at some levels. We have similar physicians who we have targeted to practice at our facilities. We pride ourselves in being extremely efficient and have a convenient Metrowest location and amenities such as free parking and childcare. These amenities have attracted both physicians and patients, and have allowed us to be successful on the recruitment front.

5) In regards to the decline in expenditures for freestanding outpatient facilities, I believe that the major rationale behind this decline is a general decrease in volume of procedures. The major cause of this, I believe, is the aforementioned directing of referrals by the hospitals back to itself, either through the employment of PCP's and specialists; "arrangements" that have been developed between hospitals and physicians, their employers or physician organizations; or through the insurance plans that hospitals creates for its employees (accounting for the largest group of patient population) heavy with penalties for utilizing facilities outside of its own.

In addition, as mentioned in the Division's Report, there has been a development of ancillary teaching hospital outpatient facilities right in our backyard, specifically. Now, in reality, their development does not necessarily take patients out of our system (remember, competition for referrals to freestanding facilities occurs at the physician level) because a patient is empowered to make a physician choice. However, in terms of

convenience, which may in fact influence a patient's physician choice, having access to facilities in the Metro West area through teaching facility expansion has negated that competitive advantage we had. However, if I were to say that they shouldn't be in our backyard, this would be hypocritical, as competition is key and is a message we want to support. The main *critical* issue is that they now get that competitive advantage *and* get it at an unlevel playing field because they get to take advantage of HOPD rates, even though they are freestanding, just because of their name. It is imperative that the Division recommends legislation to follow the example of other states, and make strict restrictions on who can bill HOPD rates and who can't (i.e. if they are not on the same property- they should bill freestanding rates). This, essentially, will decrease expenditures on its own. The Report exhibits an increase in these HOPD's volume, however, it comes at the cost of paying the increased rates. Paying ASC rates would provide a savings.

In regards to the question of volume, I believe the fact that our numbers have only decreased slightly is because of the commitment of our physicians and the quality of care we provide.

In regards to the question of affiliation, considering we are already affiliated with the NEBH, we have not considered a majority acquisition, although I truly believe that if they did not have their own facility, they would consider it.

In regards to service mix, I absolutely have considered adding additional specialties to maintain volume, but fortunately have not reached a "critical" threshold of decline to warrant such measures. In the face of declining volume and potential decline in reimbursement with Payment Reform, this is an exercise we will have to undergo to survive.

6. In an effort to not be too redundant, I would again refer the answer to this question back to # 3. I have made changes to our business model and been forced to continually recruit surgeons to practice at our facility. With the increasing underutilization of our block time, I have been constantly forced to enhance efforts in recruitment. The aforementioned "pressure" either from the hospital they are affiliated with or arrangements the hospital has with the Provider that are unbeknownst to me, has hindered my ability to execute this strategy effectively.

7. To summarize the systemic changes I have mentioned, they are as follows:
- Reduce the disparity in reimbursement methodology between ASC's and HOPD's for like services, thus leveling the playing field
 - Produce legislation that prohibits exclusive referral arrangements between hospitals and their employed physicians or physician groups
 - Prevent hospitals from directing those to whom they offer health insurance only back to their system
 - Lifting the moratorium and "no need, no file" DON legislation for ASC's, enabling ASC's to develop in areas of need, thus creating competition
 - Prevent insurance companies from penalizing patients for utilizing ASC's

- Allow ASC's to contract with MassHealth/Medicaid to provide access to that patient population

By recommending the above changes to be enacted, this will allow competition to flourish, and a level playing field that is indeed an overall change in the system. Allowing patients access to ASC's in Massachusetts will allow procedures to be done at roughly a 41% savings. The financial impact of this savings has been exhibited in numerous reports (such as the Medicare example in question # 1) on a national level, and is a simple solution that can have a profound effect in Massachusetts.

8. Competition is the foundation of business models, and more importantly creating better products or enhancements of that product leading to success or failure. By leveling the playing field between HOPD's and ASC's in Massachusetts, competition would be enhanced. In every state other than MA, patients, and more relatively state expenditures have benefited from ASC development. I am intimately aware of conversations with a major insurer in Massachusetts who has realized this impact, and looks to level the playing field on their level. Unfortunately, this is an uphill battle, as battling the deep pockets and the deeper relationships that hospitals have developed with political personnel prevent this from occurring. The fact that the Division is allowing those familiar with ASC's like myself to even comment in a forum such as this can have a tremendous impact. You have the power now to recommend changes and intervene in Massachusetts, and hopefully, these efforts will continue to be a catalyst for national changes.

8a) The MAASC and its members have long advocated for transparency, both in quality measures and reimbursement rates. I had the pleasure of working with the DPH on the HealthCare Acquired Infections and Serious Reportable Events Committee in determining the appropriateness of reporting quality measures under the new legislation. I can testify that from day one, we shared with them that as part of our extensive accreditation processes that all ASC's go through, we collect all of this data already, and to simply report it would not be a burden. In fact, we have urged this exact act to occur at not only a state level, but a national level, as this information would allow us to "put our money where our mouth is" and exhibit facts such as the results of an ASC Association Survey in 2007 where:

- 71% of ASC's did not have a single complication per 1,000 patient encounters
- 69% did not have a hospital transfer
- > 90% of ASC's report 3 or fewer infections per 1,000 patient encounters

We champion ourselves as being higher quality, this data is already obtained, transparency would allow us to be compared to hospitals on a similar basis. And, better yet, benchmarking is a key motivator for success.

In terms of reimbursement rates, I believe the transparency will divulge a myriad of inequalities that exist particularly on an ASC to HOPD basis, but even more appropriately on a hospital to hospital basis. We were all made aware of the "special" favorable reimbursement Partners was receiving after the whistle was blown in a Boston Globe article a while back. A service is a service; and it should have a value that is fixed

which it warrants. By achieving transparency, the Division will have ammunition to achieve parity and will therefore be enabled to prevent these "special" arrangements as above.

9. I believe that my comments made above reflect drivers of change which can be enacted to enhance access for patients to freestanding ASC's. This access, in turn, will provide a more cost-effective solution to increasing expenditures on health care in Massachusetts. My fear, as I have mentioned, is that too much effort will be put into exercises such as Payment Reform or Accountable Care Organizations, when the answers may lie right before the Division's eyes with the education put forth by my testimony and those of my colleagues. Accounting for the recommendations I have provided today and utilizing systems that are already in place, namely ASC's, will be far less effort for the Division.

10. I want to conclude with a simple story. My family and friends often ask me what the impact of health care reform will have on my profession as an ASC Administrator. I always say to them that although I am not necessarily for payment reform and the changes it may bring in potential further declines in reimbursement, I do think that ASC's and their potential would flourish. If the proper "powers that be" truly understood the fact that more patients can be cared for in a more efficient, safer and higher quality fashion, and all at a significantly decreased price, it would be criminal not to let ASC's flourish. We exist, we have a history of success, and the solution is right in front of you. Decreasing the restrictions on ASC's will accomplish a significant goal of the Division, saving Massachusetts money and putting the economy back on the right path.

SECOND REGULAR SESSION

HOUSE BILL NO. 1855

95TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES SCHAAF (Sponsor), MEINERS, ATKINS AND SANDER (Co sponsors).

4726L.011

D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To amend chapter 197, RSMo, by adding thereto one new section relating to hospitals.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Chapter 197, RSMo, is amended by adding thereto one new section, to be known as section 197.710, to read as follows:

197.710. 1. No hospital shall require a physician to agree to make referrals to that hospital or any hospital-affiliated facility as a condition of receiving medical staff membership or medical staff privileges.

2. No hospital shall refuse to grant medical staff membership or privileges, condition or otherwise limit medical staff membership or privileges, or limit a physician's medical staff participation because the physician, or a partner, associate, employee, or family member of the physician, provides medical or health care services at, or has an ownership interest in, or occupies a leadership position on the medical staff of another hospital, hospital system, or health care facility.

3. No hospital or hospital system shall refuse to grant a physician, or a partner, associate, employee, or family member of the physician, participatory status in a hospital or hospital system health plan because the physician, or a partner, associate, employee, or family member of the physician, provides medical or health care services at, or has an ownership interest in, or occupies a leadership position on the medical staff of another hospital, hospital system, or health care facility.

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